Missouri

Medicaid/MC+ Fee-For-Service

Recipient Handbook

Department of Social Services

Division of Medical Services

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INTRODUCTION

Welcome to Missouri Medicaid and Missouri MC+! This handbook explains the services you can get. It also tells you about your responsibilities. Please read it carefully and keep it in a safe place.

You must meet certain income guidelines and other rules to become eligible for Medicaid/MC+. Your local Family Support Division caseworker made this decision for you. If you have questions about your eligibility contact your local Family Support Division caseworker.

The Department of Social Services (DSS), Division of Medical Services (DMS) oversees the Medicaid and MC+ programs.

MC+ refers to the statewide medical assistance program for low-income families, pregnant women, children and uninsured parents. MC+ recipients get their care either through MC+ Fee-for-Service or through MC+ Managed Care. How you receive your care depends on where you live in Missouri.

Medicaid refers to the fee-for-service program for elderly and disabled recipients.

This handbook is for those who have Medicaid/MC+ Fee-for-Service. We will use the term "Medicaid/MC+" throughout the handbook but keep in mind this is for Fee-for-Service and not Managed Care.

If you are enrolled in MC+ Managed Care, this handbook is **not** for you. Call your MC+ Managed Care health plan. Ask them to send you their member handbook.

CONTACT US

For Medicaid/MC+ service related questions you can call, write or e-mail the **Recipient Services Unit (RSU)** at:

Division of Medical Services
Recipient Services Unit
PO Box 3535
Jefferson City MO 65102

1-800-392-2161 or (573) 751-6527

E-mail: ASK.DMS@dss.mo.gov

Web site: www.dss.mo.gov/dms

The toll free number, 1-800-392-2161, is an Interactive Voice Response (IVR) line. If you have a touch-tone telephone you can get information about yourself or your family without talking to anyone.

To use the IVR line, follow these instructions:

- You will need the identification number from the red Medicaid/MC+ card. Listen carefully and follow the directions.
- Choose option 1 if you want to find out if you are eligible.
- Choose option 2 if you want to hear the information in your file about your Medicare and private insurance.
- If you have questions about what you hear, you can push zero (0) to ask for an operator.

If you have questions about your **eligibility,** contact your local Family Support Division (FSD) caseworker.
The Recipient Services Unit **cannot** help you with food stamps or cash benefits information. Contact your local Family Support Division caseworker.

INTERPRETER SERVICES

If you do not speak English you can ask for an interpreter when you call the Recipient Services Unit. Tell them the language you speak. They will get an interpreter on the phone to help you.

Si usted no habla inglés usted puede preguntar un intérprete cuándo usted llama la unidad de servicios del recipiente. Dígales la lengua que usted habla. Conseguirán a intérprete en el teléfono ayudarle.

The provider is responsible if you need an interpreter when you get services.

Those who are hearing or speech impaired should call Relay Missouri for text telephone at 1-800-735-2966 and for voice at 1-800-735-2466.

ELIGIBILITY

You must have Medicaid/MC+ on each day you get services for Medicaid/MC+ to pay. You have to pay for services you get on the days you do not have Medicaid/MC+.

You must show your red Medicaid/MC+ card each time you get services. If you do not show your red card, you may have to pay for the services.

Each person must only use his or her own card. Medicaid/MC+ cannot be shared.

Not all recipients have the same coverage. Watch for special messages about this in this handbook.

If you need a new red plastic card contact your local Family Support Division caseworker.

CHANGES YOU NEED TO REPORT

- Changes you **must** report immediately to your local Family Support Division caseworker include:
  - Size of household, including a new baby
  - Name change
  - Change in income
  - Address or telephone number change
  - When you start or stop private or group insurance
  - Resources (elderly/disabled only)

- The following changes can be reported to the Recipient Services Unit at 1-800-392-2161:
  - Address change
  - When you start or stop private or group insurance

CONFIDENTIALITY

Your Medicaid/MC+ information is private.

If you want the Recipient Services Unit to talk about your case with someone else, you have to tell the Recipient Services Unit.

If someone has Power of Attorney or Guardianship for you, send a copy of this information to the Recipient Services Unit, PO Box 3535, Jefferson City, Missouri, 65102.

If you gave a copy to your local Family Support Division caseworker let the Recipient Services Unit know. They will get a copy from your local Family Support Division caseworker.

You can ask for a "Consent to Release" form from the Recipient Services Unit. This form will let you give the Recipient Services Unit permission to talk about your case with someone else.

PROVIDERS
Finding an Enrolled Provider

You must use Medicaid/MC+ fee-for-service providers for your services to be paid.

- Medicaid/MC+ can only pay providers who are enrolled. To search for a Missouri Medicaid/MC+ provider, please visit the following link: https://www.prod.dss.mo.gov/mwrm Showing your red card every time you get services will help to make sure your provider is a Medicaid/MC+ fee-for-service enrolled provider.

You may call the Recipient Services Unit at 1-800-392-2161 and ask for a list of Medicaid/MC+ fee-for-service enrolled providers.

You will need to know the types of providers you need (physician, dentist, etc.)

You may ask for the list of providers by city, zip code, county or statewide.

Even if a provider name is on the list that does not mean the provider will see you. Providers may limit the number of Medicaid/MC+ patients they will see.

APPOINTMENTS

Respect your providers. Always be on time for your appointment.

If you can't keep an appointment, always call to let them know.

To cancel an appointment call at least 24 hours ahead or go by their office rules.

Be polite and courteous to your providers. Providers do not have to enroll with Missouri Medicaid/MC+. It is their choice to do so.

BILLS

What to do if you get a bill and thought Medicaid/MC+ should have paid.

You may get a bill for a date of service when you had Medicaid/MC+. **Do not ignore this bill.** Call the provider and ask them to bill Missouri Medicaid/MC+.

If the provider still bills you, send the bill or a copy of the bill to the Recipient Services Unit, P.O. Box 3535, Jefferson City, MO 65102. Include a note with the patient name and Medicaid/MC+ number.

The Recipient Services Unit will look into the bill and decide if it can be paid. The Recipient Services Unit will send you a letter. A copy of the letter will be sent to the provider. You should get the letter within 30 days. If you do not get the letter within 30 days you may ask for a State Fair Hearing.

If the bill was not paid because the provider made a mistake, you do not have to pay the bill. If you make the mistake, Medicaid cannot pay the bill.

The provider has one year from the date of service to bill Medicaid/MC+.

If your eligibility was approved after you got the services, the provider has a choice of whether to bill Medicaid/MC+ or to bill you. It is your job to tell the provider you have Medicaid/MC+.

A Medicaid/MC+ enrolled provider may not want to bill Medicaid/MC+ for some services. The provider must tell you and have you sign an agreement saying you will pay for the service before you get the service. You will have to pay for the bill if you sign. You do not have to sign but the provider may not see you.

MEDICAID/MC+ RECIPIENT REIMBURSEMENT (MRR)

There is a program that may pay you back for services you paid for if the Family Support Division denied your application for Medicaid/MC+ by mistake. You could have had a hearing or the caseworker could have found the mistake.

You can only be paid back for services that are covered by Medicaid/MC+. You will be paid the amount Medicaid/MC+ would have paid the provider. This may be less than what you paid.

You should ask your local Family Support Division caseworker to help you. Your caseworker must complete an IM-64 form. You will need to read and sign it.

COPAYMENTS

You may have to pay a small amount for some services. This is called copayment.
Whether you have to pay and how much you pay depends on your age, the type of service and how you are eligible.

Copayment amounts range from 50 cents to 10 dollars.

Copayments for pharmacy is called a dispensing fee.

The provider will tell you how much you owe.

You are responsible to pay the provider when you get the services or when billed by the provider. If you cannot pay when you get the services, the provider must still see you. If it is the routine business practice of the provider to discontinue future services to an individual with an uncollected debt, the provider may include uncollected copyaments under this practice. In this case, the provider does not have to see you.

Copayment and a dispensing fee is a debt you owe to the provider.

Co-payments will apply to the following hospital and physician related services:

$10.00	Inpatient Hospital Services
$ 3.00	Outpatient or Emergency Room Services
$ 1.00	Physician Services
$ .50	Clinic Services
$ 1.00	X-ray and Laboratory Services
$ 1.00	Nurse Practitioner Services
$ .50	CRNA Services

$ 2.00	Rural Health Clinic Services
$ 1.00	Case Management Services
$ 2.00	Federally Qualified Health Care Services
$ 2.00	Psychology Services

For Dental, Optical and Podiatry services the following co-payments apply:

If Medicaid pays the following amount for a service:	You owe the following co-pay:
$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$51.01 or more	$3.00

These groups do not have to pay copayments:

- Recipients under 19 years of age;
- Managed Care enrollees
- Persons receiving Medicaid under a category of assistance for pregnant women or the blind;
- Services provided to you if you live in a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital;
- Services provided to you if you have both Medicare and Medicaid if Medicare covers the service and provides payment for it; or you receive Medicaid under the Qualified Medicare Beneficiary (QMB) category of assistance;
- Emergency or transfer inpatient hospital admissions;
- Emergency services provided in a hospital outpatient clinic or emergency room to treat a life threatening condition;
- Certain therapy services (physical therapy; chemotherapy; radiation therapy; chronic renal dialysis) except when provided as an inpatient hospital service;
- Family planning services;
- Services provided to pregnant women, directly related to the pregnancy or complications of the pregnancy.
- Foster care recipients;
- Personal Care services which are medically oriented tasks having to do with your physical requirements, as opposed to housekeeping requirements, which enable you to be treated by your physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility;
- Hospice services;
- Medically necessary services identified through an Early Periodic Screening, Diagnosis and Treatment screen (EPSDT);

- Mental health services; Mental Health services provided to you by community mental health facilities operated by the Department of Mental Health or designated by the Department of Mental Health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system;
- Medicaid waiver services.

RECIPIENT MEDICAID BENEFITS NOTICE

The Recipient Medicaid Benefits Notice is a list of your services that were billed to Missouri Medicaid/MC+. Random samples of the list are mailed each month to recipients, so not everyone receives a list.

This list has claims that paid and claims that did not pay. If the claim did not pay, it will tell you the reason.

If you have questions or disagree with the reason, you should contact the Recipient Services Unit at 1-800-392-2161.

If there are services on the list that you did not get, circle the service or item. Put a note with it that you did not get the service or item and mail it to the Recipient Services Unit at:

Division of Medical Services
Recipient Services Unit
PO Box 3535
Jefferson City MO 65102

STATE FAIR HEARING RIGHTS

When Medicaid/MC+ services are denied, reduced or terminated you have the right to ask for a State Fair Hearing. If you have not been given this right in a letter contact the Recipient Services Unit at 1-800-392-2161.

You have 90 days from the date of the letter to ask for a hearing. After the 90 days are up, you can no longer ask for a hearing.

After you ask for a hearing, you will be mailed a hearing form.

After you fill out the hearing form and send it back, a date will be set for the hearing.

Hearings are held on the phone. You can go to your local Family Support Division office for the hearing or you can have the hearing from your home.

You can bring anyone you want to the hearing with you. You can ask someone else to talk for you at the hearing.

Asking for a hearing will not affect your eligibility.

You will receive the hearing decision in the mail. If you do not agree with the decision you may ask for an appeal.

NON-EMERGENCY MEDICAL TRANSPORTATION

Non- Emergency Medical Transportation (NEMT) sets up transportation for Medicaid/MC+ recipients.

- You can only be given a ride to a Medicaid covered service.
- Transportation is not provided to some medical services.
- You may be asked to get a note from your doctor if the provider is over a certain number of miles away from your home.
- You do not have a choice of transportation providers.

The NEMT program will set up the transportation provider that is appropriate for you.

The NEMT program may use:

- public transportation or bus tokens,
- gas reimbursement,
- vans,
- taxi,
- ambulance, or
- airplane.

NEMT is not for emergencies. If you have an emergency, call 911 or your local emergency phone number.

In order to get NEMT services, you must be on Medicaid or MC+ on the day of your appointment.

Some people on Medicaid or MC+ do not get NEMT services. The NEMT program will let you know if you do not get NEMT.

If your child is under 21 and needs to be away from home overnight or needs someone to go along, the NEMT program can help.

- NEMT will only pay for the child and one parent or guardian.
- NEMT will not pay for other children or adults to ride along.

MC+ Managed Care recipients get their NEMT services by calling their MC+ Managed Care health plan.

There is a charge for NEMT services.

- You must pay $3 for each trip. A trip may be one way or round trip or have more than one stop
- If you cannot pay $3, your ride cannot be denied, but it may affect your ability to get a ride next time.
- You do not pay $3 if you are under age 19, pregnant, blind, or if you live in a long-term care facility.
- You do not pay $3 if you use public transportation or bus tokens or if you receive reimbursement for gas.

You have recipient rights.

- You have the right to be treated with respect and dignity.
- You have the right to privacy.
- You have the right to be free of restraint or seclusion used to make you do something you should not do.
- You have the right to exercise your rights without being worried about the way the NEMT program will treat you.

You may not always be happy with NEMT services. You can file a grievance with the NEMT program. You need to call 1-866-269-5927 or write LogistiCare, 6700 North Corporate Dr, Kansas City, MO. 64120.

If your ride is more than 15 minutes late, call one of these numbers:

- 1-866-269-5944 or 1-866-269-5435

The NEMT program will write you a letter if they do any of the following:

- Deny or give a limited approval of a service;
- Deny, reduce, suspend, or end a service already approved; or
- Deny payment for a service.

You have the right to ask for a hearing within 90 days from the date of the letter. You may ask anyone such as a family member, your minister, a friend, or an attorney to help you.
You can call the Recipient Services Unit at 1-800-392-2161 (Toll Free) or 1-573-751-6527 (at your cost) for information on a State Fair Hearing.

If you have poor eyesight, information is available in an easy to read form Call 1-800-392-2161 to get a copy.

If you are hard of hearing and use a telecommunications device for the deaf (TDD) call 1-800-735-2966.

INTERPRETER SERVICES/SERVICIOS DEL INTÉRPRETE

If you do not speak English, call 1-800-874-9426 to ask for help. We will get you a translator when needed. We may have this brochure in your language.

Si usted no habla inglés, llamada 1-800-874-9426 a pedir ayuda. Le conseguiremos un traductor cuando están necesitados. Podemos tener este folleto en su lengua.

Call Recipient Services at 1-800-392-2161 if you have questions about the NEMT program.

OUT OF STATE
How to get services not available in Missouri.

Services in states that border Missouri (Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are treated the same as if you were in Missouri. You must have Medicaid/MC+ on the date of service. The provider must be enrolled with Medicaid/MC+. The service must be covered.

You may need special services or treatment that you cannot get in Missouri.

Non-emergency services in states that do not border Missouri must be approved before you get the service.

If the service is not approved you may have to pay for the service.

Your physician or specialist in Missouri must send a letter to the Recipient Services Unit, PO Box 6500, Jefferson City, Missouri, 65102. The letter must tell these things:

- A short medical history;

- What services were tried in Missouri;
- What services you need, where the provider says you need to go, and who will provide the services;
- Why the services can't be done in Missouri.
- The provider in the other state must enroll with Missouri Medicaid/MC+ and accept our current Medicaid rates.

EXCEPTION PROCESS

Medicaid/MC+ may approve some services that are usually not covered.

Your doctor must complete a Medicaid Exception Request form.

Exceptions may be approved when:

- The item or service is needed to keep you alive;
- The item or service would greatly improve the quality of life if you are dying;
- The item or service is needed as a replacement because of tornado, flood, etc.; or
- The item or service is needed to prevent a higher level of care.

HEALTHY CHILDREN & YOUTH (HCY)
SPECIAL BENEFITS FOR CHILDREN

A child is anyone less than 21 years of age. For some recipients the age limit may be less than 19 years of age. Contact the Recipient Services Unit at 1-800-392-2161 to check.

Medicaid/MC+ has a special program for children to provide medically necessary services. The program is called Healthy Children and Youth (HCY) or Early Periodic Screening, Diagnosis and Treatment (EPSDT). Your provider can give your child these HCY/EPSDT services.

Some examples of HCY/EPSDT services include:

- child's medical history
- an unclothed physical exam
- blood and/or urine tests
- shots
- screening and testing lead levels in blood
- checking the growth and progress of the child
- vision, hearing, and dental screens
- dental care and braces for teeth when needed for health reasons
- private duty nurses in the home

- special therapies such as physical, occupational, and speech
- aids to help disabled children talk
- personal care to help take care of a sick or disabled child
- health care management
- psychology/counseling

An HCY/ EPSDT Health Screen helps children stay healthy or find problems that may need medical treatment.
If problems are found during an HCY/EPSDT checkup, Medicaid/MC+ will cover the treatment. Your doctor may have to ask for approval before the treatment can be done.

Your child needs to get regular checkups. Children between 6 months and 6 years old need to get checked for lead poisoning. You may use the chart below to record when your child gets a health or lead poison screen.

Health & Lead Poison Screen Record		
Age	**Date of Health Screen**	**Date of Lead Poison Screen**
Newborn		
By one month		
2-3 months		
4-5 months		
6-8 months		
9-11 months		
12-14 months		
15-17 months		
18-23 months		
24 months		
3 years		
4 years		
5 years		
6-7 years		
8-9 years		
10-11 years		
12-13 years		
14-15 years		
16-17 years		
18-19 years		
20 years		

Important tests your child needs are shown on the chart below: Please note these are not all the tests your child may need. Talk with your child's provider.

Age	Test
Birth	PKU Test
1-2 weeks	PKU and Thyroid Tests
12 months	TB Test, Blood Count, Blood Lead
2 years	Blood Lead Level Test
3 years	Blood Lead Level Test if in a high risk area
4 years	Blood Lead Level Test if in a high risk area
5 years	Blood Lead Level Test if in a high risk area
6 years	Blood Lead Level Test if in a high risk area

LEAD SCREENING FOR CHILDREN & PREGNANT WOMEN

A lead paint chip the size of three grains of sugar can poison a small child. High levels of lead can cause brain damage or even death. Lead in children is a common health concern. Children must be tested for lead:

- Missouri state law says that children must be tested yearly if the child is between six months and six years and lives in a high-risk area;
- when the child is one year old and again at two years;
- when the child is between six months and six years and might have been exposed to lead; and
- if the child is less than six years old and has never been tested for lead.

Your child may be at risk for lead poisoning if:

- You live in or visit a house built before 1978.
- Someone in your house works as a:
  - plumber;
  - auto mechanic;
  - printer;
  - steel worker;
  - battery manufacturer;
  - construction worker;
  - gas station attendant; or
  - other jobs that contain lead.

There are other ways your child can be poisoned. Call your doctor or county health department if you have more questions about lead poisoning.

A lead screen has two parts. First, the provider will ask questions to see if your child may have been exposed to lead. Then the provider may take some blood from your child to check for lead. This is called a blood lead level test. Children at one year old and again at two years old must have a blood lead level test. Children in a high-risk area must have a blood lead level test every year until age 6. Children with high lead levels in their blood must be treated for lead poisoning.

High lead levels in a pregnant woman can harm the unborn child. If you are pregnant, talk with your doctor to see if you may have been exposed to lead.

IMMUNIZATION (SHOTS) SCHEDULE FOR CHILDREN

Immunizations help prevent serious illness. This record will help keep track of when your children should be immunized. If your child did not get their shots at the age shown, they still need to get that shot. Talk to your provider about your child's immunizations. Children must have their immunization to enter school.

Immunization Record		
Age	Shot (Immunization)	Date Received
Birth	Hep B	
1 month	Hep B	
2 months	DTaP, Hib, IPV, PCV	
4 months	DTaP, Hib, IPV, PCV	
6 months	Hep B, DTaP, Hib, IPV, PCV, Influenza	
12 months	Hib, PCV, MMR, Var	
15 months	DTaP	
18 months	Good time to catch up	
2 years	Hep A Series, PPV	
4-6 years	DTaP, IPV, MMR	
11-12 years	Td	
Every 10 years	Td Booster (after last DTP/DTaP)	
Annually	Influenza	

COVERED MEDICAL SERVICES

Most services your provider says are needed are covered.

Your provider can tell you what is covered or you can call the Recipient Services Unit at 1-800-392-2161 for help.

The following are some examples of covered services. There are other covered services not listed here.

*Adult day health care	*Hearing aids and related services

Ambulance	Home health care
Ambulatory surgical center	Hospice, in last 6 months of life
Birthing center	Hospital, when overnight stay is required
*Comprehensive day rehabilitation	Laboratory tests and x-rays
*Dental	Maternity benefits, nurse midwife
*Diabetic supplies, and equipment	Mental health and substance abuse
*Diabetes self management training	Nursing Facility
Doctor's office visits	Outpatient, when overnight stay is not required
*Durable Medical Equipment (DME) such as oxygen, wheelchairs, walkers, and other things your doctor says you need.	*Personal Care
	*Podiatry, medical care for your feet
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) or Healthy Children & Youth (HCY) services for children	Pharmacy
	Transplant and related services
Emergency room	*Transportation to medical appointments
Family planning	*Vision

*Services may be limited or not covered based on your eligibility group or age. To find out, call the Recipient Services Unit at 1-800-392-2161 or (573) 751-6527.

NON-COVERED SERVICES

Medicaid/MC+ does not cover all medical care.

The doctor or provider can bill you for care not covered by Medicaid/MC+.

A few examples of services **not** covered are:

- Acupuncture
- Chiropractor services
- Cosmetic surgery for improving appearance
- Experimental medical procedures, drugs, equipment, etc.
- Hair transplants
- Personal comfort items
- Routine contact lenses
- Treatment of infertility
- Surgical procedures for gender change
- Sterilization reversal
- Weight control treatment

The following are services not covered by Medicaid/MC+ unless you are a child (age 20 and under) or you receive Medicaid under a category of assistance for pregnant women, the blind or you are a resident in a nursing facility:

- comprehensive day rehabilitation

- rehabilitation services (occupational, speech or physical therapy)
- diabetes self-management training
- eyeglasses
- hearing aids and all associated testing services
- apnea monitors
- artificial larynx and related items
- augmentative communication devices
- canes and crutches
- catheters
- commodes, bed pans and urinals
- CPAP devices
- decubitus care mattresses
- decubitus care pads
- enteral nutrition
- hospital beds and side rails
- humidifiers
- Bi-Pap machines
- IPPB machines
- nebulizers
- orthotics (all body braces)
- patient lifts and trapeze
- scooters
- suction pumps
- total parenteral nutrition mix, supplies and equipment
- walkers
- wheelchair accessories
- wheelchair batteries
- wheelchair repairs

There are other services not covered. If you have a question about what is not covered contact the Recipient Services Unit at 1-800-392-2161.

AMBULANCE

Ambulance services are covered if they are for **emergency services**.

The ambulance must go to the nearest hospital that can take care of the emergency.

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

If it is decided the ambulance trip was not for an emergency, you may have to pay the bill.

If you get a bill for ambulance services and you think it was an emergency, contact the Recipient Services Unit at 1-800-392-2161.

For non-emergency medical transportation call the Non-Emergency Medical Transportation (NEMT) helpline at 1-866-269-5927.

DENTAL SERVICES

Not all recipients are eligible for dental services.

Dental services (including dentures) are only covered if you are a child (age 20 and under) or you receive Medicaid under a category of assistance for pregnant women, the blind or you are a resident in a nursing facility. The treatment for an injury to your mouth, jaw or teeth or if you have a disease is covered.

We want you to have healthy teeth. Dental services such as cleanings, fillings, extractions and dentures are covered services.

You should keep your teeth clean and get regular dental checkups.

Finding a dentist enrolled with Medicaid/MC+ is not always easy. There are not very many dentists in Missouri. Only a few dentists want to enroll with Medicaid/MC+.

You may have to travel to get to a dental appointment. Call the Non-Emergency Medical Transportation (NEMT) number at 1-888-863-9513 to find out if you are eligible for NEMT or to set up a trip.

You can call the Recipient Services Unit at 1-800-392-2161for a list of enrolled dentists.
Orthodontics (braces) is covered for recipients age 20 and under if they meet special rules.

- Braces have to be approved before Medicaid/MC+ covers them.
- A dentist can measure how bad the teeth are. Medicaid/MC+ will only approve the worst cases.

HOME HEALTH SERVICES

Home health services provide medical treatment at home. The care follows a plan written by your doctor. Some of the services that can be provided are:

- Skilled nursing
- Home health aide services
- Physical therapy
- Occupational therapy
- Speech therapy

VISION SERVICES

Not all recipients are eligible for vision services.

One eye examination is allowed per year (during a 12-month period of time) if you are a child (age 20 and under) or if you receive Medicaid under a category of assistance for pregnant women, the blind or you are a resident in a nursing facility.

One eye examination is allowed every two years (during a 24 month period of time) for adults not receiving Medicaid under a category of assistance for pregnant women, the blind or residing in a nursing facility. Medical treatment is covered for eye disease or injury to the eye.

Frames are covered when the prescription for lenses meets the guidelines if you are a child (age 20 and under) or if you receive Medicaid under a category of assistance for pregnant women, the blind or you are a resident in a nursing facility.

One pair of lenses and frames is allowed every 2 years (during a 24-month period of time) if you are a child (age 20 and under) or if you receive Medicaid under a category of assistance for pregnant women, the blind or you are a resident in a nursing facility.

HOSPICE SERVICES

Hospice services are designed to meet the needs of recipients with life-limiting illnesses. It also helps their families cope with related problems and feelings.

To be eligible for hospice care a physician must say you are terminally ill.
Patients are considered terminally ill if their life expectancy is six months or less.

Hospice services only treat the terminal illness and related conditions.

Care may be provided in the home, a nursing facility or in a hospital.

If you choose to get hospice services, you cannot get Medicaid coverage for active treatment of the terminal illness.

There are five things that must happen if you choose hospice care: Physician Certification of Terminal Illness, election procedures, Hospice Election Statement, assignment of an attending physician, and development of the plan of care.

FOOT CARE

Foot care services are limited if you are not a child (age 20 and under) or if you receive Medicaid under a category of assistance for pregnant women, the blind or you are a resident in a nursing facility.

If you have a question about what is not covered contact the Recipient Services Unit at 1-800-392-2161.

EMERGENCY MEDICAL SERVICES

An emergency is when you need to call 911 or when you go to the nearest emergency room for things like chest pain, stroke, difficulty breathing, bad burns, deep cuts, heavy bleeding or gun shot wounds. (See the definition of emergency services under the **Ambulance** section of this handbook.)

An emergency room visit costs more than a doctor visit. You can help use Medicaid/MC+ tax dollars wisely by only going to the emergency room for emergencies.

Call your doctor for things like earaches, sore throats, backaches, small cuts or colds and flu. Do what your doctor tells you.

If you go to an emergency room the provider must be enrolled with Missouri Medicaid/MC+ or you may have to pay for the care you get.

In a non-bordering state, if you go to an emergency room and it **is not** an emergency, you may have to pay for the care you get.

FRAUD AND ABUSE
MISSOURI MEDICAID/MC+ ADMINISTRATIVE LOCK-IN PROGRAM

Committing Medicaid/MC+ fraud or abuse is against the law. Violators may be limited to using one provider, may be referred to the Medicaid Fraud Control Unit, or both.

Fraud is a dishonest act done on purpose.

Examples of recipient fraud are:
- Letting someone else use your Medicaid/MC+ health insurance card
- Getting prescriptions with the intent of abusing or selling drugs
- Using forged documents to get services

An example of provider fraud is:
- Billing for services not provided

Abuse is an act that does not follow good practices.

An example of recipient abuse is:
- Going to the emergency room for a condition that is not an emergency
- Misusing or abusing equipment that is provided by Medicaid/MC+
- Getting services from multiple providers of the same kind
- Trying to get more services than are necessary

An example of provider abuse is:
- Prescribing a more expensive item than is necessary.

You should report instances of fraud and abuse to:

The **Medicaid Fraud Control Unit** at (573) 751-3285, or

The **Seniors Organized to Restore Trust (SORT) group** at 1-888-515-6565, or

Division of Medical Services
Recipient Services Unit
PO Box 3535
Jefferson City MO 65102
1-800-392-2161 or (573) 751-6527

HEALTH INSURANCE

It is a good thing to have other health insurance when you have Medicaid/MC+! This saves money for the Medicaid/MC+ program.

Other health insurance must be used first if you have it. Always show all your health insurance cards, including your Medicaid/MC+ card, when getting services.

Whenever you start or stop other health insurance, you should report the change to your local Family Support Division office or to the Recipient Services Unit at 1-800-392-2161.

If you get money from an insurance company or other place because of an accident or injury, that money must be used to pay for your services. If Medicaid/MC+ already paid for your services, the money needs to be paid to Medicaid/MC+. If this happens to you, call the Third Party Liability (TPL) Unit at (573) 751-2005.

If the other health insurance has a copayment, and the policyholder is not a Medicaid/MC+ recipient, the provider may collect the copayment. If the policyholder is a Medicaid/MC+ recipient, the provider cannot collect the copayment.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

Medicaid/MC+ has a program that can help pay health insurance premiums! It may also pay coinsurance and deductibles. It is called the Heath Insurance Premium Payment (HIPP) program.

Group health insurance may be available from your employer. If it is, you must apply for the HIPP program. If the HIPP program decides it would save the state money, you must participate in the HIPP program.

You should not enroll until the HIPP program tells you it will save the state money.

It is your choice to apply for HIPP if your health insurance policy is not group health insurance.

The HIPP program only pays for policies that will save the state money.

You can apply for the HIPP program at your local Family Support Division office or by calling the HIPP Unit at (573) 751-2005. You may write to them at:

Third Party Liability Unit
HIPP Section
PO Box 6500
Jefferson City MO 65102-6500

ESTATE RECOVERY PROGRAM

Federal and State laws say that the amount spent for your Medicaid/MC+ benefits is a debt due to the State when you die. Upon death, the State may file a claim against your estate. This claim is to collect money that was paid out for your expenses. The state cannot collect more than it spent.

This program does not require you to sell your home. Your family members may receive property after the State's claim is paid.

At this time, the State does not file a claim if the deceased recipient has a spouse, blind or disabled dependent or child under 21. A claim may be filed with the spouse's estate.

The money collected in this program is put back into the State budget.

If you have questions about this program you should contact:

Third Party Liability Unit
Estate Recovery Section
PO Box 6500
Jefferson City MO 65102-6500
(573) 751-2005

MEDICARE AND MEDICAID

When you have both Medicare and Medicaid, Medicare pays first, (a Medicare supplement insurance policy would pay second) and Medicaid pays last.

Always show all of your insurance cards when getting services, including your Medicare, Medicaid and other insurance cards.

Medicaid will pay the coinsurance and deductibles for Medicaid covered services if you also have Medicare.

However, if you have a Medicare HMO, Medicaid will **not** pay your co-payment amount. Providers may bill you for this co-payment.

Medicaid has a program that may pay your Medicare Part A and Part B premiums! It may also pay your out of pocket expenses. Contact your local Family Support Division caseworker to see if you are eligible.

A Qualified Medicare Beneficiary (QMB) is eligible for the following:

- Payment of Medicare premiums - Part A and B
- Payment for the Medicare deductible and coinsurance for Medicare covered services
- You should always show the provider your QMB card

A Specified Low-Income Beneficiary (SLMB) is eligible to have their Medicare Part B premiums paid.

A Qualifying Individual (QI-1) is eligible to have their Medicare Part B premiums paid.

NURSING HOME CARE

There are two programs for recipients needing assistance in nursing homes.

The Supplemental Nursing Care (SNC) Program pays you a cash grant. This money is to be used for your nursing care expenses. You are also eligible for other Medicaid benefits. Contact your local Family Support Division caseworker for more information.

The Vendor Nursing Care Program makes payment to the nursing home provider. You are also eligible for other Medicaid benefits. The following information applies to the Vendor Nursing Care Program.

In most cases the recipient must use part of their income to help pay for the cost of care. Before paying for your care, you may keep $30.00 per month for personal expenses and money needed to pay for Medicare or medical insurance premiums if needed. If you have a spouse at home you may be able to give a portion of your income to your spouse.

There are 3 things that must be done before payment for nursing home benefits can be made. It is the nursing home provider's job to do this.

1. There must be a Pre-Long-Term-Care (PLTC) screening. The nursing home should contact the Division of Senior Services and Regulation.
2. There must be a Level 1or 2 Preadmission Screening and Resident Review (PSARR). A physician must sign and date the DA-124C form.
3. A DA-124A/B must be completed and sent with the DA-124C to the Division of Senior Services and Regulation Central Office. This will determine the level of care.

Many services are covered under the payment made to the nursing home. Some of those are:

Semi-private room and board Private room and board if medical need Therapeutic home leave days Hospital leave days Routine personal hygiene Basic hair care General personal care services Laundry services Dietary services Consultative services Therapy services Routine care items Nursing care services and supplies (catheter, decubitus ulcer care, diabetes testing supplies, douche bags, drainage sets, dressing supplies, enema supplies, sterile gloves, ice bags, incontinence care, irrigation supplies, medicine droppers and cups, needles, nursing services, ostomy supplies, suture care and supplies, syringes, tape)	General medical (insulin, antacids, laxatives, vitamins, enteral feeding and supplies, oxygen and supplies, special diets, IV therapy and supplies, etc.) Personal care items (baby powder, tissues, bibs, deodorant, disposable underpads, gowns, lotion, soap, oil, oral hygiene supplies, shaving supplies, nail clipping and cleaning) Equipment (arm sling, basin, bed and equipment, mattress, bed pans, canes, crutches, foot cradles, glucometers, heating pads, hot pack machines, patient lifts, respiratory equipment, restraints, sandbags, specimen container, urinals, walkers, water pitchers, wheelchairs)

Remaining personal funds after death:

- Upon the death of a recipient, nursing facilities are required to report the balance of all personal accounts to the Department of Social Services (DSS).
- If the DSS has paid for services, the personal funds must be used to pay the DSS back.
- If no other funds are available for funeral services, personal funds may be used before the DSS is paid.

PHARMACY

Medicaid/MC+ has had to take steps to deal with the increasing cost of drugs.

As other insurance companies have done, Medicaid/MC+ is now using a "Preferred Drug List" (PDL) to save the state money.

Some drugs on the PDL can be filled without taking any extra steps. Some drugs may require your doctor or pharmacist to make a special request before it is filled.

Because of these changes, your pharmacy may need to ask your doctor to allow a different medication to be filled. This will happen when there is another drug that is equally safe and effective, but also less expensive.

Exceptions to the PDL may be allowed for certain conditions. Your doctor must ask for a special approval.

If you are denied a drug your doctor has requested, check with your doctor or pharmacist to find out why.

You may have to pay a small cost when you get a prescription. This is called a dispensing fee.

MEDICARE PART D

If you have both Medicare Part A and/or Part B and Medicaid, you must be enrolled in a Medicare Part D drug plan. Medicare Part D covers most of your prescription drugs. The following drugs will continue to be covered by Missouri Medicaid:

- Benzodiazepines
- Barbiturates
- Some over-the-counter drugs

Your Medicare drug plan will help you pay for most of your prescription drug cost. You may have a co-payment of $1 to $3 for each prescription depending on whether it is a generic or brand name drug. If you fill more than one prescription at the same time, you will have to pay a copayment for each prescription.

If you live in a skilled nursing facility, intermediate care facility for the mentally retarded or inpatient psychiatric hospital, you do not pay a copayment.

Sources available to you for assistance with Medicare Part D are: Medicare at **www.medicare.gov** or call 1-800-MEDICARE, CLAIM at 1-800-390-3330 or Medicaid Recipient Services at 1-800-392-2161, option 1.

SPENDDOWN

Spenddown is a program in which you have an amount that you must pay or meet with bills each month before you can get Medicaid coverage. It is like an insurance premium.

To see if you are eligible for a different type of Medicaid or if you have questions about your spenddown amount, contact your local Family Support Division caseworker.

You can pay for your spenddown Medicaid coverage by:

- Signing up for Automatic Withdrawal from your bank account; or
- Sending a payment to the Division of Medical Services; or
- Taking bills to your caseworker. You will be responsible to pay the provider for services up to the time you meet your spenddown amount.

If you do not pay or meet your spenddown one month, you can still pay or meet it for the next month. You must remain eligible to get coverage.

For more information about paying your spenddown to the Division of Medical Services see the **Premium Collections** section of this handbook.

SPECIAL HEALTH CARE NEEDS

First Steps is Missouri's program for infants and toddlers with special needs.

- First Steps helps young children with special needs and their families get services. It is for children, birth to age three.
- You may contact either the Department of Elementary & Secondary Education at (314) 751-0187 or the Department of Health and Senior Services at (314) 751-6246. The Special Health Care Needs Web site is: http://www.dhss.mo.gov/SHCN/HCY.html Click on Healthy Children And Youth.

Home and Community Based Services are support services to help persons with disabilities and older Missourians live independently in their homes and communities.

- Programs include but are not limited to:

Division of Vocational Rehabilitation 1-877-222-8963

- Independent Living Waiver - ages 18 - 64, able to self-direct care
- Consumer Directed State Plan Services - age 18 or older, Medicaid eligible, able to self-direct care

MR/DD Division - Department of Mental Health - 1-800-364-9687

- Lopez Waiver - ages 0 - 18, Medicaid eligible
- MR/DD Comprehensive Waiver - mental retardation or developmental disability, Medicaid eligible
- MR/DD Community Support Waiver - mental retardation or developmental disability, Medicaid eligible

Department of Health & Senior Services - 1-800-235-5503

- Physical Disabilities Waiver - age 21 or older, Medicaid eligible
- Aged and Disabled Waiver - age 63 or older, Medicaid eligible
- AIDS Waiver - AIDS or HIV related diagnosis, Medicaid eligible
- DHSS HCY State Plan Services - ages 0 - 20, Medicaid eligible, health problems
- Hope Service - ages 0 - 20, meet financial and medical guidelines
- Adult Head Injury and TBI Program - age 21 or older, traumatic brain injury
- Service Coordination - needs and resource assessment, planning

A booklet about the above programs can be found on the Governor's Council on Disability at http://www.gcd.oa.mo.gov/ Click on Personal Independence Commission, scroll down page to Missouri's Guide to Home and Community Based Services, than click on HTML or PDF.

PREMIUM COLLECTIONS

Some eligibility groups pay a premium to the State before they get Medicaid/MC+ coverage.

These groups include Spenddown Pay-In and the Children's Health Insurance Program (CHIP) Premium Group.

Payments can be made by automatic withdrawal from your bank account or by sending a check, money order or cashier's check. Payments cannot be made in person, over the phone or by credit card.

For questions about the amount of your payment or changing your type of eligibility, contact your local Family Support Division caseworker.

For questions about whether your payment was received or to ask questions about how payments and automatic withdrawal are handled, you should call the **Premium Collections Unit at 1-877-888-2811**.

EXTENDED WOMEN'S HEALTH SERVICES

This is an eligibility type for women who lose Medicaid/MC+ or MC+ 2 months after their pregnancy ends.

This coverage is very limited. It only covers family planning and testing and treatment of Sexually Transmitted Diseases (STD).

OTHER HELPFUL CONTACTS

Department of Social Services (DSS)	(573) 751-4815
Family Support Division State Office (FSD)	(573) 751-3221
Family Support Division Information Line	1-800-392-1261
Division of Medical Services (DMS)	(573) 751-3425
Recipient Services Unit (RSU)	1-800-392-2161 (573) 751-6527
Third Party Liability Unit (TPL)	(573) 751-2005
Department of Mental Health (DMH)	1-800-364-9687
Division of Mental Retardation & Developmental Disabilities (MRDD)	1-800-207-9329
Department of Health & Senior Services (DHSS)	1-800-235-5503 (573) 751-6400
Special Health Care Needs	(573) 751-6246
Long-Term Care Ombudsman	1-800-309-3282
Missouri Care Options (MCO) (Information for those considering long-term care)	1-800-235-5503 1-800-392-0210
Tel-Link (Pregnant Women & Children)	1-800-835-5465
Missouri Division of Vocational Rehabilitation	1-877-222-8963
Seniors Organized to Restore Trust (SORT)	1-888-515-6565
Legal Aid Offices	www.mobar.org/member/legalaid.htm
Legal Aid of Western Missouri	(816) 474-6750
Legal Aid of Eastern Missouri	1-800-444-0514
Frequently Asked Recipient Questions	http://dss.missouri.gov/dms/faq/pages/faqrecip.htm
Community Leaders Assisting the Insured of Missouri (CLAIM)	1-800-390-3330